TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CONSULTANTS IN PAIN MEDICINE PA

Respondent Name
TRANSPORTATION INSURANCE CO

MFDR Tracking Number
M4-18-0317-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
SEPTEMBER 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In review of your explanation of benefits, it seems that you underpaid code J7999-KD. Please find attached office notes for review of claim and payment. Note J7999-KD is a compound drug for a pain pump refill. Morphine (660x.050) Baclofen (4.18x1000x.003)---------45.54x125%+60.00= $116.93."

Amount in Dispute: $23.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated November 1, 2017: "Payment has been made in accordance with both the Original EOR and Revised EORs I the total amounts of allowable reimbursement, $93.75. The Healthcare Provider submitted an invoice with the D60 for a documented invoice costs of $75.00. The J7799-KD has been reimbursed per documented invoice cost $75.00 + 25% markup which resulted in an allowable of $93.75. The second billed line of J7799-KD is denied as V131 because the entire cost of the compound medication is reflected in the one line that was reduced to $93.75. Nothing is recommended for the 2nd billed line. Requestor acknowledges on the Table of Disputed Services that payment was made for the disputed service in the amount of $93.75 but is seeking an additional $23.18. Respondent asserts that no additional payment is due.

The Requestor has provided no rationale to support its position that an additional $23.18 is due. To the extent that this service is not addressed by the Texas Fee Guidelines, the Respondent asserts that the Requestor has failed to meet its burden of proof to establish that the additional payment being sought is fair and reasonable or explained how and why the amount reimbursed is not fair or reasonable..."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 8, 2017	J7999-KD	$23.18	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline HCPCS Level II codes A, E, J, K, and L.
3. 28 Texas Administrative Code §134.1(f) sets out the requirements for a fair and reasonable reimbursement amount in the absence of a contract or a fee guideline.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 2 – Formatted EOR Message unavailable. Event Message – PROCEDURE STATUS CODE E FROM CMS RVU
   - 3 – In accordance with the CMS Physician Fee Schedule guidelines, this service was reduced due to the Non-Physician Practitioner (NPP) – Payment Methodology. (MNPR)
   - 4 – This service was reduced in accordance with the Workers' Compensation Fee Schedule rules for Physician Services. (MRCA)
   - 6 – Clinical Validation Reduction Based Upon Review of Documentation Submitted (V093)
   - 7 – CV: THIS CHARGE IS NOT NORMALLY BILLED SEPARATELY. (V131)
   - 9 – The charge for this procedure exceeds the fee schedule allowance. (Z710)
   - 10 – Original payment decision is being maintained. Upon review, it was determined that this claim was process properly. (ZD86)
   - 11 – Request for reconsideration. (Z254)

Issues & Findings

The health care provider, Consultants in Pain Medicine PA, contends that the total payment for the service in dispute should be $116.93. The carrier paid $93.75 based upon its very detailed rationale. In the following paragraphs, the Division first weighs the evidence brought by the requestor to establish whether its' asserted methodology meets the requirements of the applicable Division Rules.

1. What is the applicable fee guideline?

The service in dispute was billed under code J7999-KD. Review of the 2017 American Medical Association (AMA), Healthcare Common Procedure Coding System (HCPCS) finds that J7999 is described as a Compounded drug, not otherwise classified. According to the requestor, the service provided is a re-fill of an implanted pain pump.

Rule 28 Texas Administrative Code §134.203 (d) sets out the fee guideline for Healthcare Common Procedure Coding System (HCPCS) Level II code J. Paragraph J states:

> (d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
>
> (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
>
> (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or
>
> (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

J7999-KD is not listed in the Medicare DMEPOS fee schedule, nor does J7999-KD have a published Texas Medicaid rate. For those reasons, §134.203 (d)(3) points to (f) which states that reimbursement shall be provided in accordance with §134.1.

The Division concludes that reimbursement for J7999 shall be made in accordance with the Division's general fair and reasonable guidelines found at 28 Texas Administrative Code §134.1(f).

2. Did the requestor provide documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1(f) of this title?

Although the requestor provided a detailed calculation of its proposed fair and reasonable amount for J7999, it failed to articulate the reasons why the additional amount it sought was fair and reasonable when compared to the reimbursement it had already received from the carrier before filing this medical fee dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		December 7, 2017
Signature	Medical Fee Dispute Resolution Director	Date

RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.